

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: ☐ No limitations ☒ With limitations*

- 2.a. Outpatient hospital services.

Provided: ☐ No limitations ☒ With limitations*

- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State Plan.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided: ☐ No limitations ☒ With limitations*

- ~~d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.~~

~~☐ Provided: ☐ No limitations ☐ With limitations*~~

3. Other laboratory and x-ray services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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1-1-93

TN No. 92-3

HCFA ID: 7986E

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
Provided: No limitations X With limitations*
- 4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*
- 4.c. Family planning services and supplies for individuals of child-bearing age.
Provided: No limitations X With limitations*
- 5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.
Provided: No limitations X With limitations*
- b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).
Provided: No limitations X With limitations*
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatrists' services.
Provided: No limitations X With limitations*

* Description provided on attachment.

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State/Territory: Idaho

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of
limitations, if any.
☐ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health
agency or by a registered nurse when no home health agency exists in the
area.

Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the
home.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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TN No. _____

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TN # 91-20 Effective Date: 3-1-92

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

8. Private duty nursing services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

TN No. 91-20

Supersedes

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TN No. 91-19

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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Services for individuals with speech, hearing, and language disorders
(provided by or under the supervision of a speech pathologist or
audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

TN No. 91-20
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HCFA ID: 0069P/0002P

State/Territory: Idaho

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

*Description provided on attachment.

TN No. 92-3
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AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Preventive services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

b. Skilled nursing facility services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Intermediate care facility services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

TN No. 97-604
Superseded
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AMOUNT, DURATION AND SCOPE OF MEDICAL
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- 15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

TN No. 98-001
Supersedes
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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19. Case management services and Tuberculosis related services

- a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

 Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

 Provided: With limitations*

X Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Additional coverage ++

- b. Services for any other medical conditions that may complicate pregnancy.

X Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

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State/Territory: _____

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21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an ^{eligible} ~~unqualified~~ provider (in accordance with section 1920 of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

- ^{Certified}
23. Pediatric or family nurse practitioners' services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

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Supersedes 91-19 Approval Date 4-28-92 Effective Date 3-1-92
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State/Territory: Idaho

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24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Care and services provided in Christian Science sanatoria.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

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Revision: HCFA PM-87 R (BERC) ATTACHMENT 3.1 A
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~~AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY~~

g. ~~Clozapine Care Coordination associated with prescribed Clozapine therapy to entities
operating a manufacturer registered Clozapine treatment system.~~

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Attachment 3.1-A Program Description -- Table of Contents

2/2/04

This document is not official State Plan

1. Inpatient Hospitalization
- 2.a. Outpatient Hospital Services
- 2.b. Rural Health Clinics
- 2.c. Federally Qualified Health Centers
3. Other Laboratory and X-Ray Services
- 4.a. Skilled Nursing Facility Care Services
- 4.b. Health Check – Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- 4.c. Family Planning Services and Supplies for Persons of Child Bearing Age
- 5.a. Physician Services
- 5.b. Medical and Surgical Furnished by a Dentist
- 6.a. Podiatrist Services
- 6.b. Optometrist Services
- 6.c. Chiropractic Services
- 6.d. Services Under Other Practitioners
- 7.a. Home Health Visits and Licensed Nurse Services
- 7.b. Home Health Aide Services
- 7.c. Medical Supplies, Equipment and Appliances Suitable for use in the Home
- 7.d. Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services
8. Private Duty Nursing Services – 8 IS NOT A COVERED SERVICE
9. Clinic Services.
- 9.a. Mental Health Clinics
- 9.b. Ambulatory Surgical Centers (ASCs)
- 9.c. Diagnostic Screening Clinics
- 9.d. Diabetes Education and Training Clinics
10. Dental Services
11. Physical Therapy and Related Services
- 11.a. Physical Therapy Services – Independent Practitioners
- 11.b. Services for Individuals with Hearing Disorders – Audiology Services

Attachment 3.1-A Program Description -- Table of Contents

2/2/04

This document is not official State Plan

- 12. Prescribed Drugs and Prosthetic Devices and Eyeglasses
 - 12a. Prescribed Drugs
 - 12.b. Dentures
 - 12.c. Prosthetic Devices
 - 12.d. Eyeglasses
- 13.a. Diagnostic Services –13.a. IS NOT A COVERED SERVICE
- 13.b. Mammography Services
- 13.c. Preventative Services –13.c. IS NOT A COVERED SERVICE
- 13.d. Rehabilitative Services
- 14. Services for Individuals Age 65 or Older in Institutions for Mental Diseases –14 IS NOT A COVERED SERVICE
- 15.a. Intermediate Care Facility Services (other than services in an institution for mental diseases) for persons determined ... to be in need of such care
- 15.b. Including Such Services in a Public Institution ... for the Mentally Retarded or Persons with Similar Conditions
- 16. Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age
- 17. Nurse-Midwife Services
- 18. Hospice Care
- 19. Case Management and Tuberculosis Related Services
- 20. Extended Services for Pregnant Women
 - 20.a. Pregnancy-Related and Postpartum Services for a 60-Day Period after the Pregnancy Ends....
 - 20.b. Services for Any Other Medical Conditions that May Complicate Pregnancy
- 21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by an Eligible Provider
- 22. Respiratory Care Services – 22 IS NOT A COVERED SERVICE

Attachment 3.1-A Program Description -- Table of Contents
2/2/04

This document is not official State Plan

- 23. Certified Pediatric or Family Nurse Practitioners' Services
- 24. Any Other Medical Care and Any Other Type of Remedial Care Recognized under State Law, Specified by the Secretary
 - 24.a. Transportation
 - 24.b. Services of Christian Science Nurses – 24.b. IS NOT A COVERED SERVICE
 - 24.c. Care and Services Provided in Christian Science Sanatoria – 24.c IS NOT A COVERED SERVICE
 - 24.d. Nursing Facility Services for Patients under 21 Years of Age.
 - 24.e. Emergency Hospital Services
 - 24.f. Personal Care Services in Recipient's Home
- 25. Home and Community care for Functionally Disabled Elderly Individuals – 25 IS NOT A COVERED SERVICE
- 26. Personal Care Services Furnished to an Individual Who is Not an Inpatient or Resident of a Hospital, Nursing Facility, Intermediate Care Facility for the Mentally Retarded or Institution for Mental Disease – 26 IS MISSING FROM THE PROGRAM DESCRIPTION

3.1-A Amount, duration and scope of medical and remedial care and services provided:

1. Inpatient Hospital Services: Necessary inpatient hospital care is limited to forty (40) days of hospital care until July 1, 1987. Subsequent to July 1, 1987, no limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent. Payment is limited to semiprivate room accommodations unless private accommodations are medically necessary and ordered by the physician.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Excluded Services: Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from Medicaid payment unless prior approved by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by Medicare program are excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval and by the Department.

Acupuncture, biofeedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

For transplant coverage, see Attachment 3.1-E.

The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department or its designee is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

Abortion Services: The Department will only fund abortions to save the life of the mother or in cases of rape or incest as determined by the courts. Two licensed physicians must certify in writing that the mother may die if the fetus is carried to term. This certification must contain the name and address of the recipient.

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2. a. Outpatient Hospital Services: Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment. Refer to items 3.1-A-1 and 5 for excluded services and information concerning abortion services.

Excluded Services: Emergency room services are limited to six (6) visits per calendar year. Those services, however, which are followed immediately by admission on an inpatient status will be excluded from the above limitation. Visits by occupational therapists are limited to a total of one hundred (100) visits per recipient calendar year. Visits by physical therapists are limited to twenty-five (25) visits per calendar year unless preauthorized by the Department. Psychotherapy services are limited to forty-five (45) hours per calendar year. Partial care services are limited to fifty-six (56) hours per week per eligible recipient. Psychological evaluation, speech and hearing evaluations, physical therapy evaluation, and occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year. Diabetic education and training services are limited to twenty-four (24) hours of group counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

- b. Rural Health Clinics: Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code. Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.
- c. Federally Qualified Health Centers: Federally qualified health centers provided within the scope, amount, and duration of the State's medical assistance program as described under Subsection 16.03.09.144 of the state of Idaho's Rules Governing Medical Assistance.

3. Other Laboratory and X-ray Services: Other laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services: Laboratory and/or x-ray procedures which are associated with excluded services found in Sections 3.1-A.1 and 3.1-A.5 of this plan are excluded from payment.

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4. a. Skilled Nursing Facility Care Services must have prepayment authorization before payment is made. Such authorization is initiated by the self-reliance specialist who secures consultation from the Department's nursing care reviewer to review for a medical decision as to eligibility for nursing facility services and authorization of payment (age 21 and older).
- b. Health Check - Early Periodic Screening, Diagnosis, and Treatment (EPSDT). Services under Health Check are available to all MA recipients up to and including the month of their twenty-first (21st) birthday.
- i. **EPSDT Services.** EPSDT services include diagnosis and treatment involving medical care within the scope of MA, as well as dental services, eyeglasses, and hearing aids, and such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in the Idaho Title XIX State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during an EPSDT screening which are outside the coverage provided by the Rules Governing Medical Assistance must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in these rules specifically as a Medicaid covered service will require preauthorization for medical necessity prior to payment for that service. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. The additional service must be documented by the attending physician as to why it is medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department will be required prior to payment as specified in the Medical Vendor Provider Handbook. Those services that have not been shown or documented by the attending physician to be the least costly means of meeting the recipient's medical needs are the responsibility to the recipient.

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4. b. ii. **Well Child Screens.** Periodic medical screens should be completed at the following intervals as recommended by the AAP, Committee in Practice and Ambulatory Medicine, September 1987. Physicians and physician extenders will be required to bill using the appropriate Physician's Current Procedural Terminology (CPT codes) under section "Preventive Medicine Services." EPSDT RN screeners will be required to bill using codes established by the Department, except when the EPSDT RN screener is an employee of a rural health clinic, Indian health clinic, or federally qualified health clinic. One (1) screen at or by age one (1) month, two (2) months, three (3) months, four (4) months, six (6) months, and nine (9) months. One (1) screen at or by age twelve (12) months, fifteen (15) months, eighteen (18) months, and twenty-four (24) months. One (1) screen at or by age three years, age four (4) years and age five (5) years. One (1) screen at or by age six (6) years, age eight (8) years, age ten (10) years, age twelve (12) years and age fourteen (14) years. One screen at or by age sixteen (16) years, age eighteen (18) years and age twenty (20) years. One screen at initial program entry, up to the recipient's twenty-first birthday. Interperiodic medical screens are screens that are done at intervals other than those identified in the basic medical periodicity schedule in section 537, and must be performed by physician or physician extender. Interperiodic screens will be required to be billed using the correct Physician's Current Procedural Terminology (CPT) under section "Evaluation and Management." Interperiodic screens will be performed when there are indications that are medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition and there is indication that the illness or

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4. b. ii. condition may have become more severe or changed sufficiently, so that the further examination is medically necessary. Development screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and be conducted by qualified professionals. EPSDT RN screeners will routinely refer all clients to primary care providers. EPSDT clients ages two (2) weeks to two (2) years shall receive at least one (1) of their periodic or inter-periodic screens annually from a physician or physician extender unless otherwise medically indicated. A parent or guardian may choose to waive this requirement. EPSDT RN screeners will refer clients for further evaluation, diagnosis and treatment to appropriate services; e.g., physician, registered dietitian, developmental evaluation, speech, hearing and vision evaluation, blood lead level evaluation. Efforts shall be made to assure that routine screening will not be duplicated for children receiving routine medical care by a physician.

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4. b iii. **EPSDT Rehabilitation Intensive Behavioral Interventions (IBI).** Intensive Behavioral Interventions are individualized, comprehensive, proven interventions used on a short term, one-to-one basis that produce measurable outcomes which diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interest. IBI is available only to children birth through age twenty-one (21) who have self-injurious, aggressive, or severely maladaptive behavior and severe deficits in the areas of verbal and non-verbal communication; or social interaction; or leisure and play skills. IBI is available in a developmental disability agency, Idaho public school districts or other public educational agencies. IBI services cannot exceed thirty (30) hours per week in combination with developmental therapy and occupational therapy in a developmental disability agency. IBI services are limited to a three (3) year duration in developmental disability agencies, and Idaho public school districts or other public educational agencies. After three (3) years the expectation is that these clients will be reassessed and transitioned into appropriate services.

A professional qualified to provide or direct the provision of Intensive Behavioral Intervention must have at least a bachelor's degree in psychology, special education, social work, applied behavior analysis, speech and language pathology, occupational therapy, physical therapy, deaf education, elementary education or a related field or be a Licensed Professional Counselor-Private Practice; and have Department approved training and certification which addresses course work, experience, ethical standards, continuing education and demonstrated competencies.

- iv. **Vision Services.** The Department will provide vision screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens, as specified in section 537 of these rules, the vision screen is considered part of the medical screening service; i.e., eye chart. The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat

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4. b. iv. refractive error as outlined in Rules Governing Medical Assistance, IDAPA 16.03.09.122. Each eligible MA recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or the Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized.
- v. **Hearing Aids and Services.** The Department will provide hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens, in accordance with Rules Governing Medical Assistance, IDAPA 16.03.09.537, the hearing screen is considered part of the medical screening service. EPSDT hearing services will pay for audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, in accordance with Section 108, with the following exceptions: When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. When replacement hearing aids are requested, they may be authorized if the requirements in Rules Governing Medical Assistance, IDAPA 16.03.09.108.03.a. through 03.d. are met. The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.
- vi. **EPSDT Registered Nurse Screener.** A licensed professional nurse (RN) who is currently licensed to practice in Idaho, and who meets the following provisions: Can produce proof of completion of the Medicaid Child Assessment training course (or equivalent as approved by Medicaid) that: prepares the RN to identify the difference between screening, diagnosis, and treatment; and prepares the RN to appropriately screen and differentiate between normal and abnormal findings; includes at least five (5) days didactic instruction

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4. b. vi. in child health assessment, accompanied by a component of supervised clinical practice; is employed by a physician, district health department, rural health clinic, Indian health clinic, or federally qualified health clinic in order to provide linkage to primary care services; the employers must have a signed Medical Provider Agreement and provider number; and has established agreement with a physician or nurse practitioner for consultation on an as-needed basis.

- vii. **Private Duty Nursing Service (PDN).** PDN service provided by a nurse licensed to practice in Idaho to certain eligible children for whom the need for such service has been identified in an EPSDT screen. Private Duty Nursing services are nursing services provided by a licensed professional nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. The nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Professional Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services. PDN services must be authorized by the Department to delivery of service.

- (a) PDN Services must be ordered by a physician, and include: a function which cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho code and Administrative Rules of the Idaho State Board of Nursing. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes: a medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medication or other interventions; or a licensed or professional nursing assessment to evaluate the child's responses to interventions or medications.
- (b) PDN services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: Licensed Nursing Facilities (NF); and Licensed Intermediate Care Facilities for the Mentally

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4. b. vii. (b) Retarded (ICF/MR); and Licensed Residential Care Facilities; and Licensed Hospitals; and public or private school.
- (c) Services delivered must be in a written plan of care, and the plan of care must: be developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN RN or RN Supervisor and a representative from the Department; include all aspects of the medical, licensed, and personal care services medically necessary to be performed including the amount, type, and frequency of such service; and must be approved and signed by the attending physician, parent or legal guardian, and primary PDN RN or RN supervisor, and a representative from the Department; must be revised and updated as the child's needs change or upon significant change of the condition, but at least annually, and must be submitted to the Department for review and prior authorization of service.
- (d) Status Updates must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN Supervisor completing the form.
- viii. Redetermination Annually. Redetermination will be at least annually. The purpose of annual redetermination for PDN is to: Determine if the child continues to meet the PDN criteria in Rules Governing Medical Assistance, IDAPA 16.03.09.545. Assure that services and care are medically necessary and appropriate.
- ix. Factors Assessed for Redetermination. Factors assessed for redetermination include: The child is being maintained in their personal residence and receives safe and effective services through PDN services. The child receiving PDN services has medical justification and physician's orders. That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN RN supervisor, and a representative from the Department. That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in his home.

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4. b. x. Primary RN responsibility for PDN redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit to an updated plan of care to the Department prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN services. The plan of care must include all requested material outlined in Rules Governing Medical Assistance, IDAPA 16.03.09.545.03.a. through d.
- xi. Physician Responsibilities. Physician responsibilities include: Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. Order all services to be delivered by the private duty nurse. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department and facilitate the admission of the child to the appropriate medical facility.
- xii. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include: Notify the physician immediately of any significant changes in the child's medical condition or response to the service of delivery. Notify the Department within forty-eight hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time. Evaluate changes of condition. Provide services in accordance with the nursing care plan. Private Duty Nurse ensures copies of records are to be maintained in the child's home. Records of care must include: The date. Time of start and end of service delivery each day. Comments on child's response to services delivered. Nursing assessment of child's status and any changes in that status per each working shift. Services provided during each working shift. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department. In the case of LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and the rules and policies of the Idaho Board of Nursing. RN Supervisor visits

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4. b. xii. must occur at least once every thirty (30) days. Notify the physician if the combination of Private Duty Nursing Services along with other community resources are not sufficient to ensure the health or safety of the child.
- xiii. Nutritional services include intensive nutritional education, counseling, and monitoring by a registered dietitian or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Payment is made at a rate established in accordance with Rules Governing Medical Assistance, IDAPA 16.03.09.106.06. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; must not be due to obesity, and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.
- xiv. Drugs not covered by the Idaho Medicaid Program must be discovered as being medically necessary by the screening services; and must be ordered by the physician and must be authorized by the Medicaid Program prior to purchase of the drug.
- xv. Oxygen and related equipment are covered when the medical need is discovered during a screening service and is physician ordered. PRN oxygen or oxygen as needed on less than a continual basis will be authorized for six (6) months following receipt of medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.
- xvi. Respiratory Care Services: are not currently provided under the Idaho State Plan but are made available to EPSDT recipients.

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4. b. xvii. The following State Plan limitations will not apply to any eligible Medicaid child being served in Idaho under the EPSDT program. Idaho's list of services which are not currently provided or are limited under the Idaho State Plan, but are available to EPSDT recipients if discovered by the screening service and are found to be medically necessary. All services outside the Idaho State Plan will require prior authorization by the Department.
- (a) OUT-PATIENT HOSPITAL SERVICES: Limit of six (6) emergency room visits will be waived for EPSDT recipients.
 - (b) PHYSICIAN SERVICES: Limit of twelve (12) hours of psychiatric evaluations and maximum of forty-five (45) hours of psychotherapy in any twelve (12) month period will be waived for EPSDT recipients.
 - (c) HOME HEALTH SERVICES: Limit of one-hundred (100) visits per calendar year will be waived for EPSDT recipients.
 - (d). REHABILITATIVE SERVICES - DEVELOPMENTAL DISABILITIES AGENCIES: Limit of twelve (12) hours reimbursable time allowed for the combination of all evaluations or diagnostic services; limit of two-hundred (200) treatment sessions per calendar year of speech and hearing therapy; limit of maximum of thirty (30) hours per week of developmental and occupational therapy will be waived for EPSDT recipients.
 - (e) CLINICAL SERVICES - MENTAL HEALTH CLINICS: Limit of twelve (12) hours for a combination of any evaluative or diagnostic services per calendar year; limit of fifty-six (56) hours per week of partial treatment will be waived for EPSDT recipients.
 - (f) CLINIC SERVICES - DIAGNOSTIC SCREENING CLINICS: Limit of no more than five (5) hours of medical social services per recipient in each state fiscal year will be waived for EPSDT recipients.
 - (g) PERSONAL CARE SERVICES - UNDER EPSDT: Must be in excess of sixteen (16) hours of service per week.
 - (h) PROSTHETIC AND ORTHOTIC SERVICES: Limit of one refitting, repair or additional parts in a calendar year will be waived for EPSDT recipients.

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4. b. xvii. (i) CASE MANAGEMENT SERVICES: See Supplement 3 to Attachment 3.1.A.
- (j) SINGLE OR DOUBLE LUNG, AND COMBINED HEART-LUNG TRANSPLANTS. Exclusion of single lung, double lung, and heart/lung transplants will be waived for EPSDT patients. All other requirements regarding the pre-authorization of hospital stays and use of Medicare certified transplant facilities will continue to apply.
- (k) **Dental Services.** The Department will provide dental services for children through the month of their twenty-first (21st) birthday including diagnostic, preventative, restorative treatment, endodontics, periodontics, fixed and removable prosthodontics, maxillofacial prosthetics, oral surgery, orthodontics and adjunctive general services. Dental services are provided by a licensed dentist or denturist as described in Rules Governing Medical Assistance Sections 912 and 913. Specific services covered for children are stated in Rules Governing Medical Assistance 16.03.09 sections 900 through 914 and section 916.

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4. c. Family Planning Services and Supplies for Persons of Child Bearing Age:
The Department will provide family planning services which include: counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization.

Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Sterilization procedures are limited to persons who are at least twenty-one (21) years of age or older at the time of signing the informed consent form. A person over the age of 21 that is incapable of giving informed consent will be ineligible to receive Medicaid payment for the sterilization. The person must voluntarily sign the informed consent form at least thirty (30) days, but not more than 180 days, prior to the sterilization procedure. Sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are ineligible unless ordered by the court of law. Hysterectomies performed solely for sterilization are ineligible for Medicaid payment.

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5. a. Physician Services: The Department will reimburse for treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in Idaho Department of Health and Welfare Rules and Regulations Sections 16.03.09.065 and 16.03.09.070.02, and listed below.

Excluded Services: Elective medical and surgical treatments, except family planning services are excluded from Medicaid payment without prior approval by the Department. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and are excluded by the Medicare program are excluded from Medicaid payment. Non-medically necessary cosmetic surgery is excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies may be covered with prior approval by the Department.

Acupuncture services, naturopathic services, biofeedback therapy, laetrile therapy, and eye exercise therapy are excluded from Medicaid payment.

Procedures, counseling, office exams and testing for the inducement of fertility are excluded from Medicaid payment.

For transplant coverage, see Attachment 3.1-E.

Drugs supplied to patients for self-administration other than those allowed under Idaho Department and Welfare Rules and Regulations Section 03.9126 are excluded from Medicaid payment.

The treatment of complications, consequences, or repair of any medical procedure in which the original procedure was excluded from Medicaid, unless the resulting condition is life threatening as determined by the Department, is excluded from Medicaid payment.

Hysterectomies that are not medically necessary and sterilization procedures for people under twenty-one (21) are excluded from Medicaid payment.

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5. a. Payment for tonometry is limited to two (2) exams for individuals over the age of forty (40) during any twelve (12) month period (either separately or as part of a vision exam). Individuals with a diagnosis of glaucoma are excluded from this limitation.

Abortion Services: The Department will only fund abortions

- a) in cases of rape or incest, or,
- b) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. This certification must be provided by a licensed physician and must include the name and address of the woman.

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5. b. Medical and Surgical Furnished by a Dentist: The Department will reimburse for treatment of medical and surgical dental conditions by a licensed dentist subject to the limitations of practice imposed by state law, and according to the restrictions and exclusions of coverage contained in Rules Governing Medical Assistance, IDAPA 16.03.09.900 through 915.

Dentist Limitations: Elective medical and surgical dental services are excluded from Medicaid payment unless prior approved by the Department. All hospitalizations for dental care must be prior approved by the Department. Non medically necessary cosmetic services are excluded from Medicaid payment. Drugs supplied to patients for self-administration other than those allowed under Rules Governing Medical Assistance, IDAPA 16.03.09.805 through 818 are excluded from Medicaid payment.

6. a. Podiatrist's Services are limited to treatment of acute foot conditions.
- b. Optometrists' Services are limited to providing eye examination and eye glasses as described in section 12.d. Eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnoses and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services. 123
- c. Chiropractic Services are limited for payment to a total of twenty-four (24) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition. 135
- d. Services Under Other Practitioners includes those services provided a physician assistant as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1A Program Description 5a. Physician Services. 003.06
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7. Home Health Services

- a. (i) Home Health Visits: Home Health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, or licensed nurse.
- (ii) Services by a licensed nurse: Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(1).
- b. Home Health Aide Services Provided by a Home Health Agency: Home health aide visits are limited to a total of one hundred (100) visits per recipient per calendar year. Included in the total visit count is all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination.
- c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home:
- Program Requirements: To control utilization, all medical equipment and medical supplies must be ordered in writing by a physician. Items not specifically listed in the Rules Governing Medical Assistance, IDAPA 16.03.09.108, 107 and 108, will require prior authorization by the Department. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.
- d. Physical Therapy, Occupational Therapy or Speech Pathology and Audiology Services Provided by a Home Health Agency or Medical Rehabilitation Facility:
- Home Health Agency visits by Physical Therapists and Occupational therapists are limited to a total of one-hundred (100) visits per recipient per calendar year, included in the total visit is all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Speech pathology and audiology services are not provided for under home health services.

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9. Clinic Services:

Clinic services which are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to an outpatient by or under the direction of a physician and which may include those services provided by community health centers.

a. Mental Health Clinics:

Services provided in a mental health clinic are outlined in Rules Governing Medical Assistance, IDAPA 16.03.09.464 through 472. Service limitations as follows:

- (i) Psychotherapy Services: As set forth in Rules Governing Medical Assistance, IDAPA 16.03.09.469.01 through 03 are limited to forty-five (45) hours per calendar year.
- (ii) Partial Care Services: Partial care treatment will be limited to thirty - six (36) hours per week, per eligible recipient.
- (iii) Evaluation and Diagnostic Services: A combination of any evaluative or diagnostic services and care plan development is limited to twelve (12) hours for each eligible recipient per calendar year.

b. Ambulatory Surgical Centers (ASC):

Ambulatory surgical center services are outlined in Rules Governing Medical Assistance, IDAPA 16.03.09.121. Service limitations are as follows:

- (i) Must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

c. Diagnostic Screening Clinics:

Services provided in a diagnostic screening clinic are outlined in the Rules Governing Medical Assistance, IDAPA 16.03.09.460. Service limitations are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable.

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9. d. Diabetes Education and Training Clinics:

Clinics which provide diabetic education and training services are outlined in the Rules Governing Medical Assistance, IDAPA 16.03.09.128. Outpatient diabetes education and training services will be covered under the following conditions:

- (i) The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.
- (ii) The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.
- (iii) Service Description. Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.
- (iv) To receive diabetic counseling, the following conditions apply to each patient.
 - (a) The patient must have a written order by his or her primary care physician or physician extender referring the patient to the program.
 - (b) The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents.

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9. d. (v) The medical necessity for diabetic education and training are evidenced by the following:
- (a) a recent diagnosis of diabetes within ninety (90) days or enrollment with no history of prior diabetic education; or,
 - (b) uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to manifestations, or
 - (c) recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.
- (vi) Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years.
10. Dental Services: Dental services for persons who are past the month of their twenty-first (21st) birthday and without eligibility restrictions include preventative, restorative, and denturist services. Covered adult dental services are listed in Rules Governing Medical Assistance Sections 913 through 916

Dental services for women on the Pregnant Women and Children (PWC) Program are listed in Rules Governing Medical Assistance Section 912.

Dental Services Limitations: All covered dental services, limitations on specific services, excluded services, billing codes and payment policies are stated in the Rules Governing Medical Assistance 16.03.09 sections 900 through 916. A dental consultant will review requests for prior authorization, with accompanying documentation, to determine approval or denial. Procedures not recognized by the American Dental Association are not covered.

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11. Physical Therapy and Related Services:

a. Physical Therapy Services - Independent Practitioners:

Payment for physical therapy services by a licensed physical therapist as defined under 42 CFR 440.110 by direct order of a physician as a part of a plan of care, and be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office. Recipients are limited to twenty-five (25) visits per calendar year without prior authorization by the Department. Included in this limitation are outpatient hospital, independent providers, and physical therapy under school-based services and developmental disability agencies.

b. Services for Individuals with Hearing Disorders-Audiology Services

The Department will pay for audiometric services and supplies according to Rules Governing Medical Assistance, IDAPA 16.03.09.108. The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.

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Attachment 3.1A Program Description

12. A. Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records including evidence of such medical necessity. Those records shall be made available to the Department upon request. The criteria used to determine medical necessity is stated in Rules Governing Medical Assistance 16.03.09 Section 40.

1. Excluded Drug Products. The following categories and specific products are excluded:

- a) Legend drugs for which Federal Financial Participation is not available.
- b) Nonprescription items (without the Federal Legend), except permethrin, oral iron salts, disposable insulin syringes and needles.
- c) Diet supplements and weight loss products, except lipase inhibitors.
- d) Ovulation stimulants and fertility enhancing drugs.
- e) Nicotine cessation products.
- f) Medications used for cosmetic purposes.
- g) Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

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Attachment 3.1A Program Description

12. A. 2. Prior Authorization will be required for certain drugs and classes of drugs. The state utilizes the Idaho State University School of Pharmacy for literature, research, and the state Drug Utilization Review (DUR) Board, and Medicaid's Medical Director and staff pharmacists within the Division of Medicaid, as the Prior Authorization committee. Criteria used to place drugs on prior authorization is based upon safety, efficacy and clinical outcomes as provided by the product labeling of the drug. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in Section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization:

- a) Amphetamines and related CNS stimulants.
- b) Growth hormones.
- c) Retinoids.
- d) Brand name drugs when acceptable generic form is available.
- e) Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department.
- f) Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines.
- g) Medications prescribed outside of the FDA approved indications.
- h) Lipase inhibitors.
- i) FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been determined by the Department to be medically necessary.

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Attachment 3.1A Program Description

12. A. 3. Additional covered Drug Products. Additional drug products will be allowed as follows:

- a. Therapeutic Vitamins
 - i. Injectable vitamin B12 (cyanocobalamin and analogues); and
 - ii. Vitamin K and analogues; and
 - iii. Pediatric vitamin-fluoride preparations; and
 - iv. Legend prenatal vitamins for pregnant or lactating women; and
 - v. Legend folic acid; and
 - vi. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and
 - vii. Legend vitamin D and analogues.
- b. Prescriptions for nonlegend products.
 - i. Insulin; and
 - ii. Disposable insulin syringes and needles; and
 - iii. Oral iron salts; and
 - iv. Permethrin.

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Attachment 3.1A Program Description

12. A. 4. Limitation of Quantities. The state has a limitation that no more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. To provide enhanced control over this limitation, the Point of Sale (POS) system has added an early refill edit to identify medication refills provided before at least seventy five percent of the estimated days supply has been utilized. This edit can be overridden by the pharmacy if a change in dosage is ordered. The edit is designed to prevent waste and abuse of the pharmacy program by assisting providers and the Department to deny unnecessary refills, and identify clients who may be accessing multiple physicians and pharmacies and stockpiling medications. The following medications are the only exceptions to the 34 day supply limitation:

- a. Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased:
 - i. Cardiac glycosides; and
 - ii. Thyroid replacement hormones; and
 - iii. Prenatal vitamins; and
 - iv. Nitroglycerin sublingual and dermal patch products; and
 - v. Fluoride and vitamin/fluoride combination products; and
 - vi. Nonlegend oral iron salts.
- b. Oral contraceptive products may be purchased in a quantity sufficient for one (1), two (2), or three (3) cycles.

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Attachment 3.1A Program Description12. Prescribed drugs and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist:b. Dentures:

For specific coverage information see Rules Governing Medical Assistance 16.03.09 section ~~913~~ 912 through 913. (P+I)

c. Prosthetic Devices:

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body. Hearing aids and related services will be covered by the Department.

Limitations: Prosthetic and orthotic devices and services will be purchased only if prescribed by a physician and pre-authorized by the Department. All prosthetic and orthotic devices (excluding hearing aids) that require fitting shall be provided by an individual who is certified or registered by the American board for Certification in orthotics and/or prosthetics.

The Department will purchase one (1) hearing aid per recipient with prior approval of the Department. Follow up services are included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist:

d. Eyeglasses:

The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction.

Limitations: Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme medical condition preclude the use of conventional lenses.

Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus. One (1) set of frames will be purchased by the Department not more often than once every four (4) years for individuals over the age of twenty-one (21), except when documented by the physician and/or optometrist that there has been a major change in visual acuity than cannot be accommodated in the existing frames. Broken, lost, or missing glasses will not be repaired or replaced by the Department for individuals over the age of twenty-one (21).

TN # 97-008

Supersedes:

TN # 93-020

Approval Date: 9-22-97

Effective Date: 4-15-97

Attachment 3.1A Program Description

State Idaho

- 13.b. Mammography Services. Idaho Medicaid will cover screening mammographies performed with certified mammography equipment and staff. Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.

TN Number 97-004
Supercedes

Approval Date 6-6-97
Effective Date 7-1-97

13. d. Rehabilitative services are the core medical rehabilitative services to be provided on a statewide basis by:

- 1) a) Facilities which have entered into a provider agreement with the Department and are licensed as Developmental Disability Agencies (DDA's) by the Division of Family and Community Services, Bureau of Developmental Disabilities. Services provided by DDA's are outlined in the Idaho Medical Assistance Manual under Section 03.09120.
- b) Independent School Districts which have entered into a provider agreement with the Department. Services provided by Independent School Districts are outlined in the Idaho Medical Assistance Manual under Section 03.09560 through 03.09577.

These sections include the limitations of services for evaluation and treatment hours and excluded services. They are:

- i. Evaluation and diagnostic services are limited to twelve (12) hours in any calendar year.
- ii. Psychotherapy services are limited to a maximum of forty-five (45) hours per calendar year.
- iii. Speech and hearing services are limited to two hundred and fifty (250) treatment sessions per calendar year.
- iv. Physical therapy services are limited to one hundred (100) treatment sessions per calendar year.
- v. Developmental and occupational therapy services are limited to thirty (30) hours per week.
- vi. Individual Education Plan (IEP) Plan development services (Independent School District providers only) are limited to one (1) per year.
- (Pen & Ink change) → vii. Excluded services are:
 - (a) Vocational services;
 - (b) Educational services;

(c) Recreational services.

- 2) Psychosocial Rehabilitation (PSR) services provided through the State Mental Health Authority in each region. These services are outlined in the Idaho Medical Assistance Manual under Section 03.09450-03.09457. This section includes the limitations and excluded services.

a) Limitations unless otherwise authorized by the Division of Family and Community Services are:

- i. A combination of any evaluation or diagnostic services is limited to a maximum of six (6) hours in a calendar year.
- ii. Individual, family and group psychotherapy services are limited to a maximum of twenty-four (24) hours in a calendar year.
- iii. Community crisis support services are limited to a maximum of five (5) consecutive days and must receive prior authorization from the Division of Family and Community Services.
- iv. Individual and group psychosocial rehabilitation services are limited to twenty hours (20) per week and must receive prior authorization from the Division of Family and Community Services. Services in excess of twenty (20) hours require additional review and prior authorization by the Division.

b) Excluded services:

- i. Treatment services rendered to recipients residing in inpatient medical facilities including nursing facilities or hospitals.
- ii. Recreational therapy, which includes activities which are primarily social or recreational in nature.
- iii. Job-specific interventions, job training and job placement services which includes helping the

- recipient develop a resume, applying for a job, and job training or coaching.
- iv. Staff performance of household tasks and chores.
 - v. Client staffing within the same PSR agency.
 - vi. Services for the treatment of other individuals, such as family members.
 - vii. Any other services not listed in 03.09452.

TN Number: 00-006
Supersedes: 94-013

Approval Date: 05/31/2000
Effective Date: 02/01/2000

Attachment 3.1A Program Descriptions

14. a. Not provided.
- b. Skilled care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care of recipients who do not require hospital care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.
- c. Intermediate care facility services for individuals age 65 or older in institutions for mental diseases include services provided under the direction of a physician for the care and treatment of recipients who do not require hospital or skilled nursing care, but whose mental or physical condition requires services that are above the level of both room and board and can be made available only through institutional facilities.

IN # <u>90-1</u>	DATE APPROVED <u>MAR 27 1990</u>
SUPersedes	EFFECTIVE DATE <u>JAN 1 1990</u>
IN # <u>826</u>	DATE TO CO. <u> </u>
COMMENTS	

Attachment 3.1A Program Descriptions

15 & 15a

Intermediate care services including such services in a public institution for the mentally retarded or persons with related conditions must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to eligibility for intermediate care services and authorization of payment.

STATE IDAHO

Attachment 3.1-A Program Descriptions

16. Inpatient psychiatric facility services for individuals under 22 years of age are subject to the following limitations:

Services provided must meet the State's medical necessity criteria and be provided in a JCAHO accredited hospital.

TN No.: 98-001
Supersedes TN No. 93-013

Effective Date: 1-1-98
Approval Date: 2-19-98

17. Certified Nurse-Midwife Services

Those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1A Program Description 5a. Physician Services.

TN # 92-3 Approval Date: 4-28-92

Supersedes

TN # 82-6 Effective Date: 3-1-92

18. Hospice Care

The Idaho Department of Health and Welfare provides hospice services for terminally ill Medicaid recipients. In order to participate, hospices must be Medicare certified.

A. Limitations. The following limitations are contained in the State's hospice

- (1) Benefit Days. The Idaho Medicaid hospice program provides for eight benefit periods which coincide with each recipient's monthly eligibility recertifications. A recipient is provided up to eight calendar months of hospice care. The benefit period starts on the first day of the month in which hospice was elected and hospice is automatically renewed until the date of the recipient's death, revocation, or failure to meet monthly eligibility requirements. The recipient will have at least 210 hospice days available.
- (2) Respite Days. Respite days are limited to five days per benefit period (calendar month).

*IN. # 88-9
Superseded 84-6*

*approved: 1-30-89
Effective: 10-24-88*

19. Case Management Services: The Department will purchase Case Management Services for the following target groups:

- a) Mentally Ill - Adult (18 years of age or older) Medicaid recipients with severe disabling mental illness. The purpose of these services is to assist eligible individuals to gain access to needed medical, social, educational, mental health and other services.
- b) Personal Care Service Recipients - Medicaid eligible recipients who have been approved for personal care services and who require and desire assistance to adequately access services necessary to maintain their own independence in the community.
- c) Developmentally Disabled - Adult (21 years of age or older) Medicaid eligible developmentally disabled recipients; and eligible individuals between the ages of eighteen (18) and twenty-one (21) who have transition plans developed by the school system which identify service coordination (case management) as necessary. The purpose of these services is to assist eligible individuals to obtain needed health, educational, vocational, residential and social services.
- d) Pregnant and Parenting Teens and their Infants - Medicaid eligible pregnant teens seventeen (17) years of age or younger at the time of conception. Teens who qualify for case management at intake continue to qualify for case management services until the infant is one (1) year of age, so long as the goals of the case management plan have not been met. For purposes of this section, a teen is considered pregnant until 72 hours after delivery. Additionally, any Medicaid eligible teen/infant receiving targeted case management services since October 1, 1993, will be considered part of the target group. Teens and infants must live in Adams, Washington, Payette, Gem, Canyon, and Owyhee Counties.

TN # 94-016 Approval Date: 1-27-95

Supersedes

TN # 93-23 Effective Date: 10-1-94

20. A. Extended Services to Pregnant Women:

The State provides the full range of Medicaid Program services with limitations as elsewhere described in this plan to eligible women described in Section 20.a of Attachment 3.1-A if such service is related to a medical condition identified by Bureau of Medical Assistance medical consultants as pregnancy related (either routine postpartum care, or arising from complications of pregnancy, including delivery).

1. Special services related to pregnancy. When ordered by the patient's attending physician, nurse practitioner or nurse midwife, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the 60th day following delivery occurs.

(a) Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department. A single payment for each month of service provided is made.

(b) Individual and Family Medical Social Services. Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.

(c) Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits during the covered period is available.

(d) Nursing Services. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits in the covered period is provided.

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IN # 89-9	307 31 1988
SURVEILLANCE	1-1-88
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20. A. 1. (e) Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This services is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized.
- (f) Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.
20. B. The State provides the full range of Medicaid Program services, with limitations as described in this plan to eligible pregnant women during pregnancy.
21. During the presumptive eligibility period, outpatient services related to pregnancy and complications thereof and the extended services to pregnant women described in Attachment 3.1A 20 A and B. Limitations as described elsewhere in this plan are applicable.

IN - 89-9	DATE APPROVED
89-4	1-1-89
89-4	DATE TO EXPIRE
89-4	

Attachment 3.1A Program Description

STATE IDAHO

23. Certified Pediatric or Family Nurse Practitioners' Services
Those services provided by certified pediatric or family nurse practitioners as defined by state and federal law. This coverage has the same exclusions as listed in Attachment 3.1A Program Description 5a. Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners as required by Section 1905(a) (21) of the Act.

TN # 92-3 Approval Date: 4-28-92
Supersedes
TN # 91-6 Effective Date: 3-1-92

State Agency Idaho Department of Health and Welfare

MEDICAID PROGRAM: AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED

LIMITATIONS IN THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF
PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED BELOW:

- 24 a. Transportation services and assistance for eligible persons to medical facilities in the form of "necessary" transportation is provided. Transportation to medical facilities for the performance of medical services or procedures which are excluded from M.A. participation as listed in Attachment 3.1A 1 and 5 of the plan are excluded from M.A. participation.

"Necessary" transportation for full benefit Dual eligible participants to acquire their Medicare Part D prescription medications will be allowed effective January 1, 2006. Reference 42 CFR 440.170.

- b. Nursing facility care services must have prior authorization before payment is made. Such prior authorization is initiated by the eligibility examiner who secures consultation from the periodic medical review team through the nurse consultant for a medical decision as to the eligibility for skilled nursing care services and authorization of payment (under 21 years of age).
- c. Emergency Hospital Services are provided when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this plan. All obstetrical deliveries provided to aliens per Section 1903 (v) (3) of the Act are designated as emergency services.
- d. Personal Care Services are provided when ordered by a physician, supervised by a registered nurse, and approved by the Department's Regional Medicaid Unit. Services are limited to sixteen (16) hours per calendar week, per eligible client. R.N. supervision must occur at least every ninety (90) days. Clients whose provider is expected to carry out training programs in the recipient's home for developmentally disabled individuals will also have supervision at least every ninety (90) days by a Qualified Mental Retardation Professional.

TN No. 05-009Approval Date JAN 18 2006Supersedes TN No. 92-010Effective Date January 1, 2006

Revision: HCFA-PM-92-7 (MB)
October 1992

ATTACHMENT 3.1-A
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State: IDAHO

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals,
as defined, described and limited in Supplement 2 to Attachment 3.1-A,
and Appendices A-G to Supplement 2 to Attachment 3.1-A.

 provided XX not provided

TN No. 93-7
Supersedes Approval Date MAY - 4 1993 Effective Date APR - 1 1993
TN No.

MARCH 1987

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OMB NO.: 0939—0193

State/Territory: IDAHO

2. Service Plan Development and Implementation. Following the assessment(s) and determination of need for CM, a written service plan shall be developed and implemented as a vehicle to address the case management needs of the recipient. To the maximum extent possible, the development of a service plan shall be a collaborative process involving the recipient, his family or other support system, and the CM provider. The written service plan shall be developed within thirty (30) calendar days of when the recipient chooses the agency as his provider and must be signed by a licensed physician or other licensed practitioner of the healing arts within the scope of his practice under State law, indicating the services are medically necessary.
3. Linking/Coordination of Services. Through negotiation and referrals, the case manager links the recipient to various providers of services/care and coordinates service delivery. Coordination of service delivery includes activities such as assuring that needed services have been delivered, consulting with service providers to ascertain whether they are adequate for the needs of the recipient, and consulting with the client to identify the need for changes in a specific service or the need for additional services. The case manager may refer to his own agency for services but may not restrict the recipient's choice of service providers. It may be necessary to mobilize more than one set of resources to make adequate services available. The case manager may be needed to act as an advocate for the recipient. There must be a minimum of one face—to—face contact with the recipient at least every thirty (30) days.

TN No. 02-014

Approval Date: 2/10/03

Supersedes TN No. 92-006

Effective Date: 12/1/02

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: IDAHO

4. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery systems such as transportation, Meals on Wheels, etc. Such assistance must be directed toward reducing the number of case management hours needed. Such assistance is limited to thirty (30) days per service delivery system.

E. Qualification of Providers:

CM Provider Agency Qualifications. Case management provider agencies must meet the following criteria:

1. Utilization of a standardized intake and prescreening process for determining whether or not Medicaid eligible individuals are included in the target group for case management services. Prescreening must be effective in sorting out who does and who does not need a full assessment of needs for CM.
2. Demonstrated capacity in providing all core elements of case management services to the target population including:
 - i. Comprehensive assessment; and
 - ii. Comprehensive service plan development and implementation; and
 - iii. Linking/coordination of services; and
 - iv. Encouragement of independence.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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3. CM Provider Staff Qualifications: All individual CM providers must be employees of an organized provider agency that has a valid CM provider agreement with the Department. The employing entity will supervise individual CM providers and assure that the following qualifications are met for each individual CM provider:
 - i. Must be a psychiatrist, M.D., D.O.; or physician, M.D., D.O.; or licensed psychologist; or psychologist extender who is registered with the Bureau of Occupational Licenses; or social worker with a valid Idaho social work license issued by the Board of Social Work Examiners; or nurse, R.N.; or licensed clinical professional counselor; or clinician employed by a state agency and who meets the requirements of the Division of Human Resources and the Personnel Commission; or have a B.A. or B.S. in a human services field and at least one year experience in the psychiatric or mental health field. Individuals without the one (1) year of experience may gain this experience by working for over one (1) year under the supervision of a fully qualified case manager.
 - ii. At no time will the total caseload of a case manager be so large as to violate the purpose of the program or to adversely affect the health and welfare of any case management service recipient.

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OMB No.: 0939-0193

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- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- H. Program Limitation: Ongoing case management services are limited to a total of five (5) hours per calendar month. An additional three (3) hours of crisis care management are available if the individual meets established criteria. The Department may authorize additional crisis hours after the initial three (3) hours.

TN No. 03-004

Approval Date: JUL 25 2003

Supersedes TN NO. 02-014

Effective Date: 7-1-03

HCFA ID: 1040P/0016P

SUPPLEMENT 1 TO ATTACHMENT 3.1-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Idaho

- A. Target Group: Those recipients who are approved for Personal Care Services and who require and desire assistance to adequately access services necessary to maintain their own independence in the community are eligible for case management services. The scope and amount of services will be determined by the Regional Medicaid Unit based on the individual community service plan.
- B. Areas of the State Which Services Will be Provided:
- ☒ Entire State.
- ☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.
- C. Comparability of Services
- ☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- ☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

TN No. 93-017

Supersedes

TN No. 91-5

Approval Date 11-17-93

Effective Date 7-1-93

HCFA ID: 1040P/0016P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Idaho

D. Definition of Services

Service Description. Case Management Services are delivered by eligible case management agencies to recipients who have been determined eligible for Personal Care Services both under the Idaho State Plan or under the Home and Community Based Services Waiver. Case management is an individualized service provided by an employee of a qualified case management provider agency acting the role of a coordinator of multiple services to insure that the various needs of the individual are assessed and met. Case management has the following core functions:

1. Assessment. A comprehensive evaluation of the recipient's ability to function in the community including, but not limited to:
 - a. Medical needs, physical problems and strengths; and
 - b. Mental and emotional problems and strengths; and
 - c. Physical living environment; and
 - d. Vocational and educational needs; and
 - e. Financial and social needs; and
 - g. An evaluation of the community support system including the involvement of family or significant other; and
 - h. An evaluation of the community support system including involvement of family or significant other; and
 - i. Safety and risk factor; and
 - j. Legal status.

TN No. 93-017
Supersedes
TN No. 91-5

Approval Date 11-17-93

Effective Date 7-1-93
HCFA ID: 1040P/0016P

SUPPLEMENT 1 TO ATTACHMENT 3.1-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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2. Individual Community Service Plan (ICSP) Development. Based on the information obtained during the recipient assessment and input obtained from professionals involved with the recipient, the case manager will develop a written plan which will include at least the following:
 - a. Problems identified during the assessment; and
 - b. Overall goals to be achieved;
 - c. References to all services and contributions provided by informal support systems including the actions, if any, taken by the case manager to develop the support system; and
 - d. Documentation of who has been involved in the service planning, including the client's involvement; and
 - e. Schedule for case management monitoring and reassessment; and
 - f. Documentation of unmet needs and service gaps; and
 - g. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery.
 - h. The ICSP will be reevaluated and updated by the case manager at least every six months and approval continued, if appropriate, by the Regional Medicaid Unit.
 - i. A copy of the current ICSP will be provided to the recipient or their legal representative.
3. Linking/Coordination of Services. A case manager will actively advocate for services required by the client and coordinate such service delivery between multiple agencies, individuals, and others.

TN No. 93-017

Supersedes

TN No. 91-5

Approval Date 11-17-93

Effective Date 7-1-93

HCFA ID: 1040P/0016P

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4. Continuity of Care. A case manager will monitor and evaluate the services required and received by the recipient at least every thirty (30) days and is responsible to assure that the services are delivered in accordance with the individual community service plan. If new needs are identified, then the individual community service plan will be revised and the new needs addressed.
 5. The case manager will encourage independence of the recipient by demonstrating to the individual how to best access service delivery system such as energy assistance, legal assistance, financial assistance, etc. Such encouragement will be conducted on an ongoing basis.
- E. Qualifications of Providers: All individual case managers must be employees of an organized entity that has a valid provider agreement with the Department's Bureau of Welfare Medical Programs. The case management agency cannot provide Personal Care Services and case management services to the same recipient. The employing entity will supervise individual case management providers and assure that the following qualifications are met:
1. The individual case manager must be a licensed social worker or licensed professional nurse or have at least a BA or BS in sociology, recreation therapy, rehabilitation, counseling, other related human services degree, or be a qualified mental retardation professional as defined in 42 CFR 483.430, and have at least one (1) years experience of service delivery to the service population.
 2. The individual case manager must be supervised by an individual who has at least a BA or BS degree and is a licensed social worker, psychologist, or licensed professional nurse (registered nurse/RN) with at least two (2) years experience in service delivery to the service population. The supervisor will oversee the service delivery and have the authority and responsibility to remove the individual case manager if the client's needs are not met.

TN No. 93-017

Supersedes

TN No. 91-5

Approval Date 11-17-93

Effective Date 7-1-93

HCFA ID: 1040P/0016P

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3. Individual case managers will not be assigned case management responsibilities for more than thirty (30) active case management clients.

The Bureau of Medicaid Policy and Reimbursement may grant a waiver of the caseload limit when requested by an agency when the following criteria are met.

- a) The availability of case management providers is not sufficient to meet the needs of the service area.
- b) The recipient that has chosen the particular provider that has reached their limit, has just cause to need that particular manager over other available managers.
- c) The individual case manager's caseload consists of twenty-five percent or more maintenance level (two (2) hours per month or less of CM services) clients.

The request for waiver must include:

- a) The time period for which the waiver is requested; and
- b) The alternative caseload limit requested; and
- c) Documentation that the granting of the waiver would not diminish the effectiveness of the case manager's services, violate the purposes of the program, or adversely affect the health and welfare of any of the case manager's clients.

The Bureau may impose any conditions, including limiting the duration of a waiver, which it deems necessary to ensure the quality of CM services provided.

TN No. 93-017

Supersedes

Approval Date 11-17-93

Effective Date 7-1-93

TN No. 91-5

HCFA ID: 1040P/0016P

State/Territory: IDAHO

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TN No. 93-017
Supersedes Approval Date 11-17-93 Effective Date 7-1-93
TN No. 91-5 HCFA ID: 1040P/0016P

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- A. Target Group: Adult (21 years of age or older) Medicaid eligible individuals and eligible individuals between the ages of 18 and 21 who have transition plans developed by the school system which identify service coordination as a necessary service who have a primary diagnosis of a developmental disability; reside in adult foster care, residential care, semi-independent living, room and board, their own homes, or are homeless; and are receiving habilitation, supportive assistance, respite, or other services.
- B. Areas of the State Which Services Will be Provided:
- /X/ Entire State.
- / / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.
- C. Comparability of Services
- / / Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- /X/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

TN No. 94-016

Supersedes

Approval Date 1-27-95

Effective Date 10-1-94

TN No. 93-17

HCFA ID: 1040P/0016P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Idaho

D. Definition of Services

Service Description. Case management services (referred to in regulation as Targeted Service Coordination (TSC) services) shall be delivered by eligible providers to assist the Medicaid recipient to obtain and coordinate needed health, educational, vocational, residential and social services using the least restrictive and most appropriate procedures and settings. TSC shall consist of the following core functions:

1. Individual Assessment and Service Planning. An Individual Support Plan (ISP) shall be developed in conjunction with the recipient and individuals the recipient wants to include, for example his or her family, guardian, paraprofessional service coordinator and service providers.
2. Implementation. The service coordinator (SC) shall arrange for services necessary to execute the ISP.
3. Monitoring. The service coordinator shall review, update, and monitor the plan continuously to meet the recipient's changing needs.
4. Enablement. The SC shall enable the recipient whenever possible. Enablement includes but is not limited to the following: Providing information, assuring that all placements in the service delivery system are within the least restrictive environment possible, ensure that all placements are community based, ensure that all providers comply with client's rights as specified in the DD Act, assure that no one will be denied service coordination on the basis of the severity of physical or mental handicap.

E. Qualification of Providers:

TSC Provider Qualifications. Targeted service coordination will be provided by agencies that have a valid provider agreement/contract with the Department and meet the following criteria:

TN No. 94-016
Supersedes Approval Date 1-27-95 Effective Date 10-1-94
TN No. 93-017 HCFA ID: 1040P/0016P

SUPPLEMENT 1 TO ATTACHMENT 3.1-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- a) Demonstrated ability to provide all the core elements of TSC services to the target population; and
- b) Provide consumers of the agency, the availability of a service coordinator on a twenty-four (24) hour basis to assist them in obtaining needed services; and
- c) Not provide service coordination to any individual for whom the agency, owners, or employees also provide direct services; and
- d) Agency employees successfully complete the service coordination training specified by the Department prior to providing services; and
- e) Follows the written procedures for service coordination authorized and adhered to by the Department; and
- f) Adheres to the Department's mission and value statements.

TSC Provider Staff Qualifications. All service coordinators must meet the following qualifications:

- a) Must be a psychologist, Ph.D. Ed.D., M.A./M.S.; Registered Nurse, B.A./B.S. in Nursing; or possess a valid Idaho social work license issued by the Board of Social Work Examiners;
- b) Must have at least 18 months, at an average of 20 hours per week, of on-the-job experience involving service to the target population, or be working under the supervision of a fully qualified service coordinator;
- c) Must undergo a criminal history check;
- d) Must be supervised by an individual with the authority to oversee the service delivery, and to remove the individual if the recipient's needs are not met; and

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State/Territory: Idaho

- e) Cannot be the care coordinator for any recipient for whom the care coordinator has individual responsibility for the provision of developmental or other care or treatment; and
- f) Cannot be responsible for the care coordination of more than 30 individuals.

The Bureau's of Medicaid Policy and Reimbursement and Developmental Disabilities may grant a waiver of the caseload limit when requested by the agency when the following criteria are met:

- i. The availability of care coordinators is not sufficient to meet the needs of the service area; or
- ii. The recipient who has chosen the particular care coordinator who has reached their limit, has just cause to need that particular provider over other available providers; or
- iii. The individual care coordinator's caseload consists of twenty-five (25) percent or more maintenance level (two hours per month or less of care coordination services) consumers.

The request for waiver must include:

- a) The time period for which the waiver is requested; and
- b) The alternative caseload limit requested; and
- c) Documentation that the granting of the waiver would not diminish the effectiveness of the case manager's services, violate the purposes of the program, or adversely affect the health and welfare of any of the case manager's clients.

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EVERYONE
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Idaho

The Bureau may impose any conditions, including limiting the duration of a waiver, which it deems necessary to ensure the quality of CM services provided.

- g. Paraprofessionals may be used to assist in the implementation of the ISP. Paraprofessionals must meet the following qualifications:
- i. Must be 18 years of age and have a high school diploma or the equivalent (G.E.D.); and
 - ii. Must be able to read and write at a level commensurate with the general flow of paperwork and forms; and
 - iii. Must complete a training program developed by the Division of Family and Community Services and be working under the supervision of a fully qualified care coordinator; and
 - iv. Must undergo a criminal history check.
- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: IDAHO

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

1. The State of _____ provides home and community care to functionally disabled elderly individuals to the extent described and defined in this Supplement (and Appendices) in accordance with section 1929 of the Social Security Act.

2. Home and community care services are available Statewide.

_____ Yes _____ No

If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify): _____

3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

- a. _____ aged (age 65 and older, or greater than age 65 as limited in Appendix B)
- b. _____ In accordance with §1929(b)(2)(A) of the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.
- c. _____ In accordance with §1929(b)(2)(A) of the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.
- d. _____ In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Additional targeting restrictions (specify):

- a. _____ Eligibility is limited to the following age groups (specify): _____

State: IDAHO

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

- b. Eligibility is limited by the severity of disease or condition, as specified in Appendix B.
 - c. Eligibility is limited to individuals who have been shown to have a need for one or more of the services elected by the State under this benefit.
- 5. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.
 - 6. Each individual served will meet the test of functional disability set forth in Appendix B.
 - 7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.
 - 8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.
 - 9. The comprehensive functional assessment is based on the uniform minimum data set specified by the Secretary. Check one:
 - a. The State will use the assessment instrument designed by HCFA.
 - b. The State will use an assessment instrument of its own designation. The assessment instrument to be used is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.
 - 10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.
 - 11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.
 - 12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:
 - a. identify in each such assessment or review each individual's functional disabilities and need for home and community care, including information about the individual's health status, home and community environment, and informal support system; and

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- b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.
13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the person's individual community care plan (ICCP).
14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.
15. All services will be furnished in accordance with a written ICCP which:
- a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver;
 - b. is based upon the most recent comprehensive functional assessment of the individual;
 - c. specifies, within the amount, duration and scope of service limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;
 - d. indicates the individual's preferences for the types and providers of services and documents the individual's free choice of providers and services to be furnished; and
 - e. may specify other services required by the individual.
- A copy of the ICCP format to be used in implementing this benefit is included in Appendix E.
16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.
17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.
18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 3, 4, 5 and 6 of this Supplement.
- a. Homemaker services
 - b. Home health aide services
 - c. Chore services

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- d. Personal care services
- e. Nursing care services provided by, or under the supervision of, a registered nurse
- f. Respite care
- g. Training for family members in managing the individual
- h. Adult day care
- i. The following services will be provided to individuals with chronic mental illness:
 - 1. Day treatment/Partial hospitalization
 - 2. Psychosocial rehabilitation services
 - 3. Clinic services (whether or not furnished in a facility)
- j. Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:
 - 1. Habilitation
 - A. Residential Habilitation
 - B. Day Habilitation
 - 2. Environmental modifications
 - 3. Transportation
 - 4. Specialized medical equipment and supplies
 - 5. Personal Emergency Response Systems
 - 6. Adult companion services
 - 7. Attendant Care Services
 - 8. Private Duty Nursing Services
 - 9. Extended State plan services (check all that apply):
 - A. Physician Services
 - B. Home health care services

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- C. _____ Physical therapy services
- D. _____ Occupational therapy services
- E. _____ Speech, hearing and language services
- F. _____ Prescribed drugs
- G. _____ Other State plan services (specify): _____
10. _____ Other home and community based services (specify): _____
19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.
20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice, or the provider(s) of their choice, or who disagree with the ICCP which has been established.
21. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.
22. The State provides the following assurances to HCFA:
- a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.
 - b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).
 - c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.
 - d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990 and will be provided in the manner prescribed by HCFA. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

State: IDAHO

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES FOR THE CATEGORICALLY NEEDY

- e. The home and community care provided in accordance with this Supplement and Appendices will meet all requirements for individual's rights and quality of care as are published or developed by HCFA.
 - 1. All individuals providing care are competent to provide such care; and
 - 2. Each provider of services under this benefit will meet the requirements applicable to the provision of home and community care as set forth in Appendix C.
 - 3. Each individual receiving home and community care will be accorded the rights specified in Appendix F.
 - 4. Case managers will comply with all standards and procedures set forth in Appendix E.
- 23. FFP will not be claimed for the home and community care services specified in item 18 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:
 - a. the average number of individuals in the quarter receiving home and community care;
 - b. the average per diem rate of Medicare payment for extended care services (without regard to coinsurance) furnished in the State during such quarter; and
 - c. the number of days in such quarter.
- 24. Community care settings in which home and community care is provided will meet the requirements set forth in section 1929(g) and (h) of the Act, as applicable to the specific setting. The State assures that the requirements of Appendix G will be met for each setting in which home and community care is provided under this section.
- 25. The State will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.
- 26. The State will comply with the requirements of section 1929(i), of the Act, regarding survey and certification of community care settings, as set forth in Appendix G.
- 27. The State will comply with the requirements of section 1929(i) of the Act, regarding the compliance of providers of home and community care and reviews of this compliance, as set forth in Appendix C.
- 28. The State will provide for an enforcement process for providers of community care, as required by section 1929(j) of the Act. This process is described in Appendix C.

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29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under title XIX or title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under title XIX or title XI of the Social Security Act if there is no reasonable legal ground for the provider's case.
31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date):

These services will be provided to eligible individuals for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of Federal financial participation available to the State.
33. The State assures that it will monitor the appropriateness and accuracy of the assessments and reviews. Through its monitoring, the State assures the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

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State: IDAHO

MEDICAID ELIGIBILITY GROUPS SERVED

- a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B.
- b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply):
 1. Age 65 or older who have been determined to be functionally disabled (as determined under the SSI program) as specified in Appendix B.
 - A. The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate). Individuals must be receiving SSI/SSP benefits to be eligible under this provision.
 - B. The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A. Individuals must be eligible for Medicaid under the State's plan to be eligible under this provision.
 2. Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):
 - A. The State does not consider anticipated medical expenses.
 - B. The State considers anticipated medical expenses over a period of months (not to exceed 6 months).

State: IDAHO

INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

- a. The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, the following individuals will be eligible to receive home and community care services. (Check all that apply):

1. Age 65 or older.
2. Disabled, receiving SSI.

These individuals meet the resource requirement and income standards that apply in the State to individuals described in §1902(a)(10)(A)(ii)(V) of the Act.

- b. In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

- c. In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older, who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. This waiver was terminated during the period in which the State furnished home and community care to functionally disabled elderly individuals under its State plan. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

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State: IDAHO

FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

- a. Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.
- b. Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.
- c. Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
- d. Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):
 1. at least 3 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
 2. at least 4 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
 3. all of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
- e. Services are provided to individuals who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are sufficiently cognitively impaired so as to require substantial supervision from another individual because they engage in inappropriate behaviors that pose serious health or safety hazards to themselves or others.

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AGE

Check all that apply:

- a. _____ Services are provided to individuals age 65 and older.
- b. _____ Services are provided to individuals who have reached at least the following age, greater than 65 (specify): _____
- c. _____ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.
- d. _____ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.
- e. _____ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):
 1. _____ Age 65 and older
 2. _____ Age greater than 65. Services are limited to those who have attained at least the age of (specify): _____
 3. _____ Age less than 65. Services will be provided to those in the following age category (specify): _____
 4. _____ The State will impose no age limit.

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State: IDAHO

INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

- a. In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers):

Waiver Number	Last date of waiver operation
---------------	-------------------------------

_____	_____
_____	_____
_____	_____
_____	_____

- b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).
- c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.
- d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.
- e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were reevaluated for financial eligibility (specify):

Waiver Number	Reevaluation schedule
---------------	-----------------------

_____	_____
_____	_____
_____	_____
_____	_____

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State: IDAHO

DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. Homemaker Services. (Check one.)

 Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

 Other Service Definition: _____

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. The State will impose the following limitations on the provision of this service (specify): _____

b. Home Health Aide Services. (Check one.)

 Services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

 Other Service Definition: _____

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State: IDAHO

DEFINITION OF SERVICES (con't)

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. The State will impose the following limitations on the provision of this service (specify):

c. Chore Services. (Check one.)

 Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider), or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

 Other Service Definition: _____

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. The State will impose the following limitations on the provision of this service (specify):

State: IDAHO

DEFINITION OF SERVICES (con't)

Provider qualifications are specified in Appendix C-2.

d. Personal Care Services. (Check one.)

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the individual community care plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as bedmaking, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

Other Service Definition: _____

1. Services provided by family members. Check one:

 Payment will not be made for personal care services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.

Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

 a registered nurse, licensed to practice nursing in the State

case managers

other (specify): _____

State: IDAHO

DEFINITION OF SERVICES (con't)

3. Minimum frequency or intensity of supervision:
_____ as indicated in the client's ICCP
_____ other (specify): _____
4. Personal care services are limited to those furnished in a recipient's home.
_____ Yes _____ No
5. Limitations (check one):
_____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
_____ The State will impose the following limitations on the provision of this service (specify): _____

- e. _____ Nursing Care Services Provided By or Under The Supervision of a Registered Nurse.

Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

State: IDAHO

DEFINITION OF SERVICES (con't)

f. _____ Respite care. (Check one.)

Services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Other Service Definition: _____

1. Respite care will be provided in the following location(s):
 - _____ Recipient's home or place of residence
 - _____ Foster home
 - _____ Facility approved by the State which is not a private residence
2. The State will apply the following limits to respite care provided in a facility.
 - _____ Hours per recipient per year
 - _____ Days per recipient per year
 - _____ Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.
 - _____ Not applicable. The State does not provide facility-based respite care.
3. Respite care will be provided in the following type(s) of facilities.
 - _____ Hospital
 - _____ NF
 - _____ ICF/MR
 - _____ Group home
 - _____ Licensed respite care facility

State: IDAHO

DEFINITION OF SERVICES (con't)

_____ Other (specify): _____

_____ Not applicable. The State does not
provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient's home).

_____ Hours per recipient per year
_____ Days per recipient per year

_____ Respite care will be provided in
accordance with the ICCP. There are no
set limits on the amount of
community-based respite care which may be
utilized by a recipient.

_____ Not applicable. The State does not
provide respite care outside a
facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.

- g. _____ Training for Family Members in Managing the Individual.
(Check one.)

_____ Training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual, and may include a spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

_____ Other Service Definition: _____

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Check one:

1. ☐ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. ☐ The State will impose the following limitations on the provision of this service (specify):

Provider qualifications are specified in Appendix C-2.

h. ☐ Adult Day Care. (Check one.)

☐ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

☐ Other Service Definition: _____

Check all that apply:

1. ☐ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.
2. ☐ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.
3. ☐ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

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4. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.
5. _____ Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.
6. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Limitations. Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

- i. _____ Services for individuals with chronic mental illness, consisting of (Check all that apply):

1. _____ Day Treatment or other Partial Hospitalization Services. (Check one.)

_____ Services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

- a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

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- b. occupational therapy, requiring the skills of a qualified occupational therapist,
- c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,
- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

Other Service Definition: _____

Limitations. Check one:

- a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

2. _____ Psychosocial Rehabilitation Services. (Check one.)

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_____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- o Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);
- o Social skills training in appropriate use of community services;
- o Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- o Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services,
Prevocational services,
Supported employment services,
Educational services, and
Room and board.

_____ Other Service Definition: _____

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

- a. _____ Individual's home or place of residence
- b. _____ Facility in which the individual does not reside
- c. _____ Other (Specify): _____

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Limitations. Check one:

- a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- b. _____ The State will impose the following limitations on the provision of this service (specify): _____

Qualifications of the providers of this service are found in Appendix C-2.

3. _____ Clinic Services (Whether or Not Furnished in a Facility)
are services defined in 42 CFR 440.90.

Check one:

- a. _____ This benefit is limited to those services furnished on the premises of a clinic.
- b. _____ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify): _____

Check one:

- a. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- b. _____ The State will impose the following limitations on the provision of this service (specify): _____

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Qualifications of the providers of this service are found in Appendix C-2.

j. _____ Habilitation. (Check one.)

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully at home or in the community. This service includes:

1. _____
Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-B.
2. _____
Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

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Check all that apply:

- A. _____ Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.
- B. _____ Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.
- C. _____ Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.
- D. _____ Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.
- E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.
- F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify): _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

- k. _____ Environmental Modifications. (Check one.)

_____ Those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

2. _____ The State will impose the following limitations on the provision of this service (specify): _____

1. _____ Transportation. (Check one.)

_____ Service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

m. _____ Specialized Medical Equipment and Supplies. (Check one.)

_____ Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This

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DEFINITION OF SERVICES (con't)

service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

n. _____ Personal Emergency Response Systems (PERS). (Check one.)

_____ PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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2. _____ The State will impose the following limitations on the provision of this service (specify): _____

o. _____ Adult Companion Services. (Check one.)

_____ Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

_____ Other Service Definition: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

- A. _____ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.

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- B. _____ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1. _____ Family members who provide adult companion services must meet the same standards as other adult companion providers who re unrelated to the recipient. These standards are found in Appendix C-2.
2. _____ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.

p. Attendant Care. (Check one.)

Hands-on care, of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

Other Service Definition:

Check all that apply:

1. _____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

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DEFINITION OF SERVICES (con't)

2. _____ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client's ICCP.
3. _____ Other supervisory arrangements: _____

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
2. _____ The State will impose the following limitations on the provision of this service (specify): _____

Provider qualifications are specified in Appendix C-2.

q. _____ Private Duty Nursing. (Check one.)

_____ Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

_____ Other Service Definition: _____

Check one:

1. _____ Private duty nursing services are limited to services provided in the individual's home or place of residence.

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2. _____ Private duty nursing services are not limited to services provided in the individual's home or place of residence.

Check one:

- A. _____ Services may also be provided in the following locations (Specify):

- B. _____ The State will not place limits on the site of private duty nursing services.

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify):

- r. _____ Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _____ Physician services.

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

- B. _____ The State will impose the following limitations on the provision of this service (specify):

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DEFINITION OF SERVICES (con't)

2. Home Health Care Services

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- B. _____ The State will impose the following limitations on the provision of this service (specify):

3. Physical Therapy Services

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- B. _____ The State will impose the following limitations on the provision of this service (specify):

4. Occupational Therapy Services

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- B. _____ The State will impose the following limitations on the provision of this service (specify): _____

5. Speech, Hearing and Language Services

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

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DEFINITION OF SERVICES (con't)

- B. _____ The State will impose the following limitations on the provision of this service (specify): _____

6. Prescribed Drugs

Check one:

- A. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

- B. _____ The State will impose the following limitations on the provision of this service (specify): _____

s. Other services (specify):

Provider standards for each "other" services identified are found in Appendix C-2.

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PROVIDER QUALIFICATIONS

- a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

LICENSURE AND CERTIFICATION CHART

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HOMEMAKER			
HOME HEALTH AIDE			
CHORE SERVICES			
PERSONAL CARE			
NURSING CARE			
RESPITE CARE			
IN HOME			
FACILITY BASED			
FAMILY TRAINING			
ADULT DAY CARE			
DAY TREATMENT/ PARTIAL HOSPITALIZATION			
PSYCHOSOCIAL REHABILITATION			
CLINIC SERVICES			

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SERVICE	PROVIDER TYPE	LICENSURE	CERTIFICATION
HABILITATION			
RESIDENTIAL			
DAY			
ENVIRONMENTAL MODIFICATIONS			
TRANSPORTATION			
MEDICAL EQUIPMENT AND SUPPLIES			
PERSONAL EMERGENCY RESPONSE SYSTEMS			
ADULT COMPANION			
ATTENDANT CARE			
PVT DUTY NURSING			

Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

Identify any additional standards applicable to each service on a separate sheet of paper. Attach the paper to this Appendix.

b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.
2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.
3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of elderly individuals. The degree of familiarity must be commensurate with the type of service to be provided.

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2. If the provider is to furnish services to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.
3. The provider must furnish proof of sufficient ability to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.
4. Each provider must have received training, appropriate to the demands of the service to be provided, in proper response to emergency situations. This training must include instruction in how to contact the client's case manager.
5. Each provider must be qualified by education, training, experience and/or examination in the skills necessary for the performance of the service.
6. Providers may meet these standards by the following methods:
 - A. Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.
 - B. Specific course(s), identified in the provider qualifications for the service to be furnished.
 - C. Documentation that the provider has completed the equivalent of the course(s) identified in item c.6.B, above.
 - D. Training provided by the Medicaid agency or its designee.

The Medicaid agency or its designee will also make this training available to unpaid providers of service.

Yes

No
 - E. Appropriate experience (specified in the provider qualifications for the applicable service) which may substitute for the education and training requirements otherwise applicable.
 - F. The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers, and particular services, the State may also choose to require satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.

Specific standards of education, training, experience, and/or demonstration of competence applicable to each service provided are attached to this Appendix.

d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

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In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service.

SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
HOMEMAKER	
HOME HEALTH AIDE	Providers of Home Health Aide services meet the qualifications set forth at 42 CFR Part 484 for the provision of this service under the Medicare program. Additional qualifications:
CHORE SERVICES	
PERSONAL CARE	
NURSING CARE	
RESPITE CARE	
IN HOME	
FACILITY BASED	
FAMILY TRAINING	
ADULT DAY CARE	
DAY TREATMENT/PARTIAL HOSPITALIZATION	Day treatment/partial hospitalization services are furnished by a hospital to its outpatients, or by a community mental health center. They are furnished by a distinct and organized ambulatory treatment center which offers care less than 24 hours a day.
PSYCHOSOCIAL REHABILITATION	
CLINIC SERVICES	
HABILITATION GENERAL STANDARDS	
RESIDENTIAL HABILITATION	
DAY HABILITATION	

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SERVICE	MINIMUM QUALIFICATIONS OF PROVIDERS
ENVIRONMENTAL MODIFICATIONS	
TRANSPORTATION	
MEDICAL EQUIPMENT AND SUPPLIES	
PERSONAL EMERGENCY RESPONSE SYSTEMS	
ADULT COMPANION	
ATTENDANT CARE	
PVT DUTY NURSING	

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.

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ASSESSMENT

- a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in items 3 and 4 of Supplement 2.
- b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.
- c. The individual will not be charged a fee for this assessment.
- d. Attached to this Appendix is an explanation of the procedures by which the State will ensure the performance of the assessment.
- e. The assessment will be reviewed and revised not less often than (check one):
 1. _____ Every 12 months
 2. _____ Every 6 months
 3. _____ Other period not to exceed 12 months (Specify): _____

- f. Check one:
 1. _____ The State will use an assessment instrument specified by HCFA.
 2. _____ The State will use an assessment instrument of its own specification. A copy of this instrument is attached to this Appendix. The State certifies that this instrument will measure functional disability as specified in section 1929(b) and (c) of the Act. The State requests that HCFA approve the use of this instrument, and certifies that at such time as HCFA may publish a minimum data set (consistent with section 1929(c)(2) of the Act), the assessment instrument will be revised, as determined necessary by HCFA, to conform to the core elements, common definitions, and uniform guidelines which are contained in the minimum data set.
- g. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:
 1. Identify in each such assessment or review each individual's functional disabilities; and
 2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:
 - A. Information about the individual's health status;
 - B. Information about the individual's home and community environment; and
 - C. Information about the individual's informal support system.

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ASSESSMENT (con't)

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.
- h. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.
- i. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. All problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.

State: IDAHO

INTERDISCIPLINARY TEAM

- a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. ☐ The interdisciplinary teams will be employed directly by the Medicaid agency.
2. ☐ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.
3. ☐ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.
4. ☐ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.

- b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. ☐ The interdisciplinary teams will be employed directly by the Medicaid agency.
2. ☐ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.
3. ☐ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.
4. ☐ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

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State: IDAHO

INTERDISCIPLINARY TEAM (con't)

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.

c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. ☐ Registered nurse, licensed to practice in the State
2. ☐ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. ☐ Physician (M.D. or D.O.), licensed to practice in the State
4. ☐ Social Worker (qualifications attached to this Appendix)
5. ☐ Case manager
6. ☐ Other (specify): _____

d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply, but at least 2):

1. ☐ Registered nurse, licensed to practice in the State
2. ☐ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. ☐ Physician (M.D. or D.O.), licensed to practice in the State
4. ☐ Social Worker (qualifications attached to this Appendix)
5. ☐ Case manager
6. ☐ Other (specify): _____

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State: IDAHO

INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

- a. A written individual community care plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.
- b. The ICCP will be established, and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face to face interview with the individual or primary caregiver.
- c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.
- d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.
- e. The ICCP will indicate the individual's preferences for the types and providers of services.
- f. The ICCP will specify home and community care and other services required by such individual. (Check one):
1. Yes 2. No
- g. The ICCP will designate the specific providers (who meet the qualifications specified in Appendix C-2) which will provide the home and community care. (Check one):
1. Yes 2. No
- h. Neither the ICCP, nor the State, shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.

State: IDAHO

QUALIFIED COMMUNITY CARE CASE MANAGERS

- a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community care case management.
1. Be a nonprofit or public agency or organization;
 2. Have experience or have been trained in:
 - A. Establishing and periodically reviewing and revising ICCPs; and
 - B. The provision of case management services to the elderly.The minimum standards of experience and training which will be employed by the State are attached to this Appendix;
 3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.
 4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):
 - A. ☐ Registered nurse, licensed to practice in the State
 - B. ☐ Physician (M.D. or D.O.), licensed to practice in the State
 - C. ☐ Social Worker (qualifications attached to this Appendix)
 - D. ☐ Other (specify): _____

- b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services and will not furnish home and community care or nursing facility services itself. (Check one):
1. ☐ Yes
 2. ☐ Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.
- c. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such managers. An explanation of these procedures is attached to this Appendix.

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State: IDAHO

QUALIFIED COMMUNITY CARE CASE MANAGERS (con't)

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. Yes 2. No
3. Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

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COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

- a. A qualified community care case manager is responsible for:
1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;
 2. Visiting each individual's home or community care setting where care is being provided not less often than once every 90 days;
 3. Informing the elderly individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.
 4. Completes the ICCP in a timely manner; and
 5. Reviews and discusses new and revised ICCPs with elderly individuals or primary caregivers.
- b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.
1. Yes 2. No
- c. Whenever a qualified community care case manager is informed by an elderly individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.
1. Yes 2. No
- d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.
1. Yes 2. No

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COMMUNITY CARE CASE MANAGEMENT FUNCTIONS (con't)

- e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):
1. Yes 2. No
- f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall verify the qualifications of the individual or entity furnishing the services, and as necessary, provide or arrange for the training specified in Appendix C-2. (Check one):
1. Yes 2. No
3. Not applicable. All services are governed by State licensure or certification requirements.
- g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

State: IDAHO

RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

- a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.
- b. Individuals receiving home and community care shall be assured the following rights:
 1. The right to be fully informed in advance, orally and in writing, of the following:
 - a. the care to be provided,
 - b. any changes in the care to be provided; and
 - c. except with respect to an individual determined incompetent, the right to participate in planning care or changes in care.
 2. The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. A description of the procedures which the State will utilize to ensure this right is attached to this Appendix.
 3. The right to confidentiality of personal and clinical records.
 4. The right to privacy and to have one's property treated with respect.
 5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.
 6. The right to education or training for oneself and for members of one's family or household on the management of care.
 7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.
 8. The right to be fully informed orally and in writing of the individual's rights.

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State: IDAHO

ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

- a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.
- b. In the case of an individual who has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the individual are exercised by the person appointed under State law to act on the individual's behalf.
- c. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law. In addition, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall be extended to the principal caregiver.
- d. In the case of an individual who resides in a community care setting, and who has not been adjudged incompetent by the State court, any legal-surrogate designated in accordance with State law may exercise the individual's rights to the extent provided by State law.

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GUIDELINES FOR PROVIDER COMPENSATION

- a. The following advisory guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.
1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.
A. Yes B. No
 2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.
A. Yes B. No
 3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.
A. Yes B. No
- b. The State assures that it will comply with these guidelines.
1. Yes 2. No
- c. The methods by which the State will reimburse providers are described in attachment 4.19-B.

State: IDAHO

COMMUNITY CARE SETTINGS-GENERAL

a. Definitions.

1. Small residential community care setting. A small residential community care setting is defined as a facility in which between 3 and 8 unrelated adults reside, and in which personal services (other than merely board) are provided in conjunction with residing in the setting. To qualify as a small residential community care setting, at least one resident must receive home and community care under this benefit.
2. Small nonresidential community care setting. A small nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves between 3 and 8 individuals, at least one of which receives home and community care under this benefit at the setting.
3. Large residential community care setting. A large residential community care setting is a facility in which more than 8 unrelated adults reside, and in which personal services are provided in conjunction with residing in the setting. To qualify as a large residential community care setting, at least one resident must receive home and community care under this benefit.
4. Large nonresidential community care setting. A large nonresidential community care setting is defined as a facility in which an organized program is operated (by the facility or on the premises of the facility) which serves more than 8 individuals, at least one of which receives home and community care under this benefit at the setting.
5. Unrelated adults. Unless defined differently under State law, for purposes of this benefit, unrelated adults are individuals who are 18 years of age or older, and who do not have any of the following relationships to other adults resident in the facility: spouses, parent (including stepparent) or child (including stepchild), or siblings.
6. Personal services. Personal services are those services provided to the individual by the setting, which are intended to compensate for the absence, loss, or diminution of a physical or cognitive function. Personal services, as defined here, are not equated with personal care services available under either 42 CFR 440.170, or personal care services provided under the home and community care benefit.

b. The State will provide home and community care to individuals in the following settings:

1. _____ Nonresidential settings that serve 3 to 8 people.
2. _____ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.
3. _____ Nonresidential settings that serve more than 8 people.

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State: IDAHO

COMMUNITY CARE SETTINGS-GENERAL

4. Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.
 5. Not applicable. The State will not provide services in these types of community care settings.
- c. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.
- d. FFP will not be claimed for home and community care which is provided in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.

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SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

a. The setting shall protect and promote the rights of each client, including each of the following rights:

1. The setting shall extend to each client the right to choose a personal attending physician.
2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.
3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.
4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.
5. Restraints may only be imposed -
 - A. to ensure the physical safety of the individual or other clients served in the setting, and
 - B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).
6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.
7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.
8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

State: IDAHO

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.
 10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.
 11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.
 12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.
- b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.
- c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.
- d. A small nonresidential community care setting must extend to each individual served the following access and visitation rights.
1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.
 2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.
 3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.
 4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.
 5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.

State: IDAHO

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

- e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.
1. The setting may not require clients to deposit their personal funds with the setting, and
 2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.
 3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.
 4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

- f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:
1. The setting must deposit any amount of personal funds in excess of \$50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.
 2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.
 3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches \$200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.
 4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal funds (and a final accounting of such funds) to the individual administering the client's estate.

State: IDAHO

SMALL NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

- g. Each small nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.
- h. Each small nonresidential community care setting must meet any applicable State and local certification or license, zoning, building and housing codes, and State and local fire and safety regulations.
- i. Each small nonresidential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients.
- j. Nothing in this section shall be construed to require a small nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.
- k. Except to the extent dictated otherwise by State law, a small nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

The requirements of this Appendix shall apply to small nonresidential community care settings.

The State will require that small nonresidential community care settings meet requirements specified in this Appendix.

- a. The setting shall protect and promote the rights of each client, including each of the following rights:
1. The setting shall extend to each client the right to choose a personal attending physician.
 2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.
 3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.
 4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.
 5. Restraints may only be imposed -
 - A. to ensure the physical safety of the individual or other clients served in the setting, and
 - B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).
 6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.
 7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.
 8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.
 10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.
 11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.
 12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.
 13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plan of remedial action in effect with respect to the setting.
- b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.
- c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.
- d. A small residential community care setting must extend to each individual served the following access and visitation rights.
1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the clients individual physician or case manager.
 2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.
 3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.
 4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.
- e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.
 1. The setting may not require clients to deposit their personal funds with the setting, and
 2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.
 3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.
 4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.
- f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:
 1. The setting must deposit any amount of personal funds in excess of \$50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.
 2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.
 3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches \$200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.
 4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal funds (and a final accounting of such funds) to the individual administering the client's estate.

State: IDAHO

SMALL RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

- g. Each small residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.
- h. Each small residential community care setting must meet any applicable State and local, certification, licensure, zoning, building and housing codes, and State and local fire and safety regulations.
- i. Each small residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of residents.
- j. Nothing in this section shall be construed to require a small residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.
- k. Except to the extent dictated otherwise by State law, a small residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.

State: IDAHO

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large nonresidential community care settings.

The State will require that large nonresidential community care settings meet requirements specified in this Appendix.

- a. The setting shall protect and promote the rights of each client, including each of the following rights:
 1. The setting shall extend to each client the right to choose a personal attending physician.
 2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.
 3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.
 4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.
 5. Restraints may only be imposed -
 - A. to ensure the physical safety of the individual or other clients served in the setting, and
 - B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients until such an order can reasonably be obtained).
 6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups.
 7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.
 8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the

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health or safety of the individual or other clients would be endangered.

9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.
 10. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.
 11. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.
 12. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting and any plans of remedial action in effect with respect to the facility.
- b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.
- c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.
- d. A large nonresidential community care setting must extend to each individual served the following access and visitation rights.
1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.
 2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.
 3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.
 4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.

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5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(iii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.
- c. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.
 1. The setting may not require clients to deposit their personal funds with the setting, and
 2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.
 3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.
 4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

- d. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:
 1. The setting must deposit any amount of personal funds in excess of \$50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.
 2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.
 3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches \$200 less than the dollar amount determined under section 1611(a)(3)(B) of the Social Security Act and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.
 4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal funds (and a final accounting of such funds) to the individual administering the client's estate.

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- e. Each large nonresidential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.
- f. Each large nonresidential community care setting must be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.
- g. Nothing in this section shall be construed to require a large nonresidential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the facility.
- h. Except to the extent dictated otherwise by State law, a large nonresidential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.
- i. A large nonresidential community care setting must be licensed or certified under applicable State and local law.
- j. A large nonresidential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.
1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.
- _____ Yes _____ No
2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of nonresidential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association for those particular settings.
- _____ Yes _____ No
- k. Each large nonresidential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.

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October 1992

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State: IDAHO

LARGE NONRESIDENTIAL COMMUNITY CARE SETTINGS (con't)

1. A large nonresidential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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State: IDAHO

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS

The requirements of this Appendix shall apply to large residential community care settings.

The State will require that large residential community care settings meet requirements specified in this Appendix.

- a. The setting shall protect and promote the rights of each client, including each of the following rights:
 1. The setting shall extend to each client the right to choose a personal attending physician.
 2. Each client shall be fully informed in advance about care and treatment, and of any changes in care or treatment that may affect his or her well-being.
 3. Each client shall have the right to participate in planning care and treatment or changes in care or treatment. For clients who have been adjudged incompetent, this right shall be extended to the individual who has been appointed to make decisions on behalf of the client.
 4. The setting shall ensure that each client has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the individual's medical symptoms.
 5. Restraints may only be imposed -
 - A. to ensure the physical safety of the individual or other clients served in the setting, and
 - B. only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances when such restraints are determined to be necessary to prevent immediate and significant threat to the life or safety of the individual, staff members, or other clients) until such an order can reasonably be obtained.
 6. The setting shall ensure the right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of client groups. This shall not be construed to require the setting to furnish a private bedroom for the individual.
 7. The setting shall preserve the individual's right to confidentiality of personal and clinical records. The setting shall grant the individual (or legal representative) access to any current clinical records maintained by the setting upon request of the individual or legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

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8. The setting shall extend to the individual the right to receive services consistent with the individual's needs and preferences and the types of services provided by the setting, except where the health or safety of the individual or other clients would be endangered.
 9. The individual shall have the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the setting to resolve those grievances the client may have, including those with respect to the behavior of other clients.
 10. The setting shall extend to the client the right to receive notice before the room or the roommate of the resident in the setting is changed.
 11. The setting shall extend to the client the right to organize and participate in client groups in the setting and the right of the client's family to meet in the setting with the families of other clients in the setting.
 12. The setting shall not restrict the right of the client to participate in social, religious and community activities that do not interfere with the rights of other clients in the setting.
 13. The setting shall extend the right to examine, upon reasonable request, the results of the most recent survey of the setting conducted by HCFA or the State with respect to the setting.
- b. In the case of an individual adjudged incompetent under the laws of the State, the rights of the client shall devolve upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the individual's behalf.
- c. Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the individual's ICCP) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each client receiving such drugs.
- d. A large residential community care setting must extend to each individual served the following access and visitation rights.
1. Permit immediate access to any client by any representative of HCFA, by any representative of the State, by an ombudsman or agency described in section 1919(c)(2)(B)(iii)(II), (III), or (IV) of the Social Security Act, or by the client's individual physician or case manager.
 2. Permit immediate access to a client, subject to the client's right to deny or withdraw consent at any time, by the immediate family or other relatives of the client.
 3. Permit immediate access to a client, subject to reasonable restrictions and the client's right to deny or withdraw consent at any time, by others who are visiting with the consent of the client.

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4. Permit reasonable access to a client by any entity or individual that provides health, social, legal, or other services to the client, subject to the client's right to deny or to withdraw consent at any time.
 5. Permit representatives of the State ombudsman (described in section 1919(c)(2)(B)(ii)(II) of the Social Security Act), with the permission of the client (or the client's legal representative) and consistent with State law, to examine a client's clinical records.
- e. If the setting receives or holds funds from its clients, or exercises control over client funds, on a permanent or temporary basis, the setting must meet the following requirements.
1. The setting may not require clients to deposit their personal funds with the setting, and
 2. Upon the written authorization of the client, the setting must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this Appendix.
 3. The setting must purchase a surety bond, or otherwise provide assurance satisfactory to the secretary, to assure the security of all personal funds of clients deposited with the setting.
 4. The setting may not impose a charge against the personal funds of a client for any item or service for which payment is made under the plan or under Medicare.

Nothing in this Appendix shall be construed as requiring a setting to receive or hold funds from a client.

- f. If the setting receives or holds funds from a client, the setting must manage and account for the personal funds of the client deposited with the facility as follows:
1. The setting must deposit any amount of personal funds in excess of \$50 with respect to a client in an interest bearing account (or accounts) that is separate from any of the setting's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the setting must maintain such funds in a non-interest bearing account or petty cash fund.
 2. The setting must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a client deposited with the setting, and afford the client or legal representative, reasonable access to such record.
 3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches \$200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.

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State: IDAHO

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

3. The setting must notify each client receiving home and community care services when the amount in the client's account reaches \$200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the client's other nonexempt resources) reaches the amount determined under such section the client may lose eligibility for such medical assistance or for SSI benefits.
4. Upon the death of a client with such an account, the community care setting must convey promptly the client's personal finds (and a final accounting of such funds) to the individual administering the client's estate.
- g. Each large residential community care setting shall be required to inform each individual receiving community care under this section in the setting, orally and in writing at the time the individual first receives community care in the setting, of the individual's legal rights with respect to such a setting and the care provided in the setting.
- h. Each large residential community care setting shall be designed, constructed, equipped and maintained in a manner to protect the health and safety of clients, personnel and the general public.
- i. Nothing in this section shall be construed to require a large residential community care setting to provide or arrange for medical care or treatment to clients served under this benefit if the setting does not provide this care to other clients who receive similar services in the setting.
- j. Except to the extent dictated otherwise by State law, a large residential community care setting shall not be held responsible for the actions or inactions of persons not employed by the setting, who furnish medical care or treatment on its premises, when the setting has not arranged for the provision of care by these persons.
- k. A large residential community care setting must be licensed or certified under applicable State and local law.
- l. A large residential community care setting must meet such provisions of the most recent edition of the Life Safety Code of the National Fire Protection Association as are applicable to the type of setting.
 1. The State requests that HCFA waive certain provisions of this Code, which if rigidly applied would result in unreasonable hardship upon a setting. The State certifies that such a waiver would not adversely affect the health and safety of clients or personnel. The specific request for waiver and supporting documentation are attached.

_____ Yes _____ No
 2. The State certifies to HCFA that there is in effect a fire and safety code, imposed by State law, which adequately protects clients and personnel in certain types of residential community care settings. The specific types of settings are identified in attached documentation. The State requests that the provisions of the State code be substituted for those of the Life Safety Code of the National fire Protection Association.

_____ Yes _____ No

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State: IDAHO

LARGE RESIDENTIAL COMMUNITY CARE SETTINGS (con't)

- m. Each large residential community care setting must disclose persons with an ownership or control interest (including such persons as defined in section 1124(a)(3) of the Social Security Act) in the setting.
- n. A large residential community care setting may not have, as a person with an ownership or control interest in the setting, any individual or person who has been excluded from participation in the program under Medicaid or who has had such an ownership or control interest in one or more community care settings which have been found repeatedly to be substandard, or to have failed to meet the requirements of this Appendix.

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TN No.

CASE MANAGEMENT SERVICES

- A) Target Group: Medicaid eligible children age birth to twenty-one (21) years of age who meet the medical necessity criteria.

Medical Necessity Criteria: Medical necessity criteria for Service Coordination (SC) services under EPSDT are as follows: Children eligible for SC must meet one of the following diagnostic criteria: Children who are diagnosed with a physical or mental condition which has a high probability of resulting in developmental delay or disability, or children with developmental delay or disability. Developmentally delayed children are children with or without established conditions who by assessment measurements have fallen significantly behind developmental norms in one or more of the five functional areas which include cognitive development; physical development including vision and hearing; communication; social/emotional development; and adaptive skills. Children who have special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize disability. Special health care needs may include a wide range of physical, mental, or emotional limitations from birth defects, illness, or injuries. Children who have been diagnosed with a severe emotional/behavioral disorder under DSM-IV or subsequent revisions or another classification system used by the Department; and expected duration of the condition is at least one (1) year or more. Children eligible for SC must have one (1) or more of the following problems associated with their diagnosis: The condition requires multiple services providers and treatments; or the condition has resulted in a level of functioning below age norm in one (1) or more life areas, such as school, family, or community; or there is risk of out-of-home placement or the child is returning from an out-of-home placement as a result of the condition; or there is imminent danger to the safety or ability to meet basic needs of the child as a result of the condition; or further complications may occur as a result of the condition without provision of services coordination services; and the family needs a service coordinator to assist them to access medical and other services for the child.

- B) Areas of the State which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

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C) Comparability of Services.

- ☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- ☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D) Description of Service.

SC services shall be delivered by eligible providers to assist the Medicaid child and their family to obtain and coordinate needed health, educational, early intervention, advocacy, and social services identified in an authorized SC plan developed by the Department or their contractor. Services must take place in the least restrictive, most appropriate and most cost effective setting. SC services shall consist of the following core functions: Coordination/Advocacy, which is the process of facilitating the child's access to the services, evaluations, and resources identified in the service plan. The case manager may advocate on behalf of the child and family for appropriate community resources and coordinate the multiple providers of social and health services defined in the service plan to avoid the duplication of services for the child. Monitoring, which is the ongoing process of ensuring that the child's service plan is implemented and assessing the child's progress toward meeting the goals outlined in the service plan and the family's satisfaction with the services. Direct in-person contact with the child and the child's family is essential to the monitoring process. Evaluation, which is the process of determining whether outcomes have been reached on the service plan, the need for additional revised outcomes, the need for a new plan, or if services are no longer needed. Evaluation is accomplished through periodic in-person reassessment of the child, consultation with the child's family and consultation and updated assessment from other providers. The addition of new services to the plan or increase in the amount of an authorized service on the existing plan must be authorized by the Department prior to implementation. Crisis Assistance, which are those SC activities that are needed in emergency situations in addition to those identified on the service plan. These are necessary activities to obtain needed services to ensure the health or safety of the child. To the extent possible the plan should include instructions for families to access emergency services in the event of a crisis. If a need for twenty-four (24) hour availability of service coordination is identified, then arrangements will be made and included on the plan. Encouragement of Independence, which is the demonstration to the child, parents, family, or legal guardian of how to best access service delivery systems.

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E) Qualifications of Providers.

SC provider agencies must have a valid provider agreement with the Department and meet the following criteria: Demonstrated experience and competency in providing all core elements of service coordination services to children meeting the medical necessity criteria. Level of knowledge sufficient to assure compliance with regulatory requirements. Adherence to provision of provider agreement for EPSDT service coordination. Provider agreement may include, but is not limited to, requirements for training, quality assurance, and personnel qualifications.

Service Coordination Individual Provider Staff Qualifications. All individual SC providers must be employees of an organized provider agency that has a valid SC provider agreement with the Department. The employing entity will supervise the individual SC providers and assure that the following qualifications are met for each individual SC provider: Must be a licensed M.D., D.O., social worker, R.N., or have at least a B.A./B.S. in human/health services field; and have at least one (1) year's experience working with children meeting the medical necessity criteria. Individuals without the one (1) year experience may gain this experience by working for one (1) year under the supervision of an individual who meets the above criteria. Paraprofessionals, under the supervision of a qualified SC, may be used to assist in the implementation of the service plan. Paraprofessionals must meet the following qualifications: be eighteen (18) years of age and have a high school diploma or the equivalent (G.E.D.); be able to read at a level commensurate with the general flow of paperwork and forms; meet the employment standards and required competencies of the provider agency; and meet the training requirements according to the agency provider agreement. Pass a criminal history background check. The caseload of service coordinators will be limited to fifty (50) when using one (1) or more paraprofessionals to implement the plan. If not using paraprofessionals, the individual service coordinator's caseload shall not exceed thirty-five (35). At no time will the total caseload of a service coordinator be so large as to violate the purpose of the program or adversely affect the health and welfare of any children served by the service coordinator. A waiver to the caseload limit may be granted by the Department on a case by case basis and must meet the following criteria: The availability of service coordinators is not sufficient to meet the needs of the service area; or the recipient's family who has chosen the particular service coordinator who has reached his limit, has just cause to need that particular provider over other available providers; or the individual service coordinator's caseload consists of twenty-five percent (25%) or more maintenance level (two (2) hours per month or less of service coordination services) recipients; and the request for waiver must include: The time period for which the waiver is requested; and the alternative caseload limit requested; and documentation that the granting of the waiver would not diminish the effectiveness of the service coordinator's services, violate the purpose of the program, or adversely affect the health and safety of any of the service coordinator's consumers. The Department may impose any conditions, including limiting the duration of a waiver, which they deem necessary to ensure the quality of the service coordination services provided.

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SUPPLEMENT 3 TO ATTACHMENT 3.1-A

State Idaho

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- F) The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.
- 1) Eligible recipients will have free choice of the providers of case management services.
 - 2) Eligible recipients will have free choice of the providers of other medical care under the plan.
- G) Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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